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III. Chemical Preservatives

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(1) *The Microbiology of Foods*, F. W. Turner, Twin City Pub. Co., Champaign, Ill., 1932

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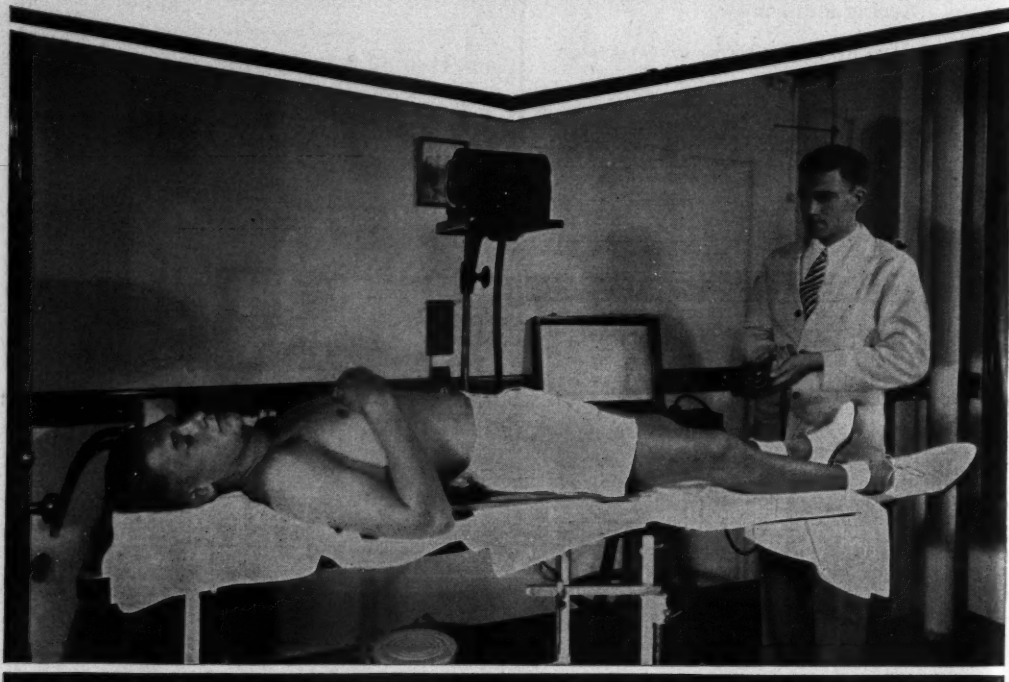
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10:00 A.M.	Breast	Breast	Bottle	Bottle
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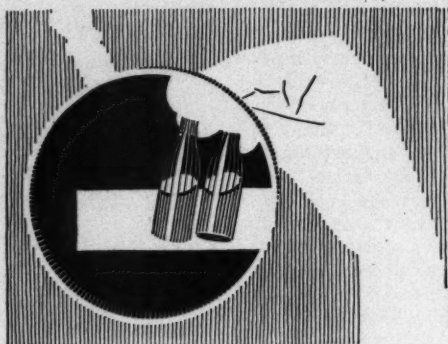
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THE CONSERVATIVE VERSUS THE RADICAL TREATMENT OF FRACTURES*

HUBLEY R. OWEN, M. D.**
Philadelphia, Pa.

There has been a marked stimulation of interest during the past few years in fracture treatment. This added interest is due to the increasing number of fractures, to fracture symposia at medical and surgical meetings, to the work of the Fracture Committee of the American College of Surgeons, to the activity of regional fracture committees, and to a popular demand for better end-results.

The diversity of methods and the ever-increasing paraphernalia and armamentarium for the treatment of fractures are somewhat confusing. Until a comparatively few years ago the methods of fracture treatment were mostly conservative, consisting of wooden or plaster-of-Paris splints, Thomas splints for treatment of fractures of the upper extremity, the application of traction on the soft parts with a Thomas splint for fracture of the femur, and the inadequate fracture box for fracture of the lower extremity. Radical treatment or open reduction was largely reserved for delayed and non-union. To these methods have been added skeletal traction with the use of Steinman pins, calipers, Kirschner wire, the Boehler technique, the Soutter apparatus, the Roger Anderson splints, Smith splint, and many others. Advocates of open reduction employ the Sherman plate, silver wire, metallic bands, nails, screws, bone pegs, bone transplants, and pin.

A visit to the fracture ward of one hospital will disclose the fact that the treatment of fractures is confined largely to conservative measures. One may find at a second hospital

that the majority of the fractures are treated by early open reduction. Equally good results may be obtained by either one of these plans of treatment. It is a question on which method gives to the individual surgeon the best results. An excellent idiom for the treatment of fractures is that the method of treatment must be suited to the individual fracture and not the fracture suited to one method of treatment. One should not be carried away by the enthusiasm of each innovation. There must be some happy medium between the ultra-conservative and the ultra-radical methods. By the conservative methods I imply the fixation of fractures by any form of external splinting and by skeletal traction. By the radical treatment is implied the open reduction with internal fixation.

There is no branch of surgery in which experience is a greater asset than with the treatment of fractures. Time has long since passed when an unreduced Colles' fracture can be treated by the application of a Bond splint for a period of four to six weeks, when a fracture of the femur with marked overlapping of the fragments can be managed by traction on the soft parts, or when a satisfactory result may be expected by treating a fracture of both bones of the lower leg in a fracture box. We assume that all surgeons are at present cognizant of certain cardinal points in the treatment of a fracture:

1st—That fractures require immediate surgical attention; that emergency treatment entails the proper application of the Murray-Jones splint for fracture involving the long bones of the upper extremity and a Keller-Blake splint for fractures involving the long bones of the lower extremity.

2nd—Immediate x-ray study.

*Read before the Medical Society of Delaware, Wilmington, October 9, 1935.

** Instructor in Surgery, Jefferson Medical College.

3rd—Reduction with local, spinal or general anesthesia.

4th—X-ray study after reduction.

5th—Careful supervision, preferably under the same surgeon, of the fracture during the entire convalescence.

These fundamental and imperative procedures will be demanded by the patient. The lack of the necessary teamwork and apparatus in any hospital to carry out these procedures may rightly be condemned.

With the treatment of a fracture, as with the treatment of any other surgical condition, I have always remembered the teaching of Dr. J. Chalmers DaCosta to the effect that: "The surgeon should place himself in the patient's predicament and employ the method of treatment which he would desire to be applied to himself." I have occasionally wondered whether the surgeon who advocates ultra-radical procedures in cases of fracture would allow similar procedures to be applied to himself. My experience with the treatment of the medical profession as patients is that they usually desire very conservative treatment.

With adequate apparatus and its proper application a large majority of fractures can be successfully treated by conservative measures. A surgeon may be handicapped in the proper management of a complicated fracture because of the lack of proper hospital equipment. This lack of equipment is poor economy, as by proper equipment in many cases the patients' hospital days can be materially lessened.

An important point in the discussion of the conservative treatment versus the open reduction of fractures is the time element between the injury and the open reduction. It should not require a number of weeks to determine whether the fragments of a fracture can be satisfactorily held by conservative measures. In the treatment of a great majority of such fractures the surgeon should be able to determine within three or four days whether or not he can succeed in obtaining satisfactory apposition of the fragments by means of conservative measures. If at the end of this time such conservative measures have failed, open reduction should not be post-

poned. This is the most important point which I desire to emphasize. Far too often weeks are lost by repeated manipulations before the decision is finally reached that the fragments cannot be held by conservative means. Every attempt at manipulation of the fragments increases the likelihood of delayed or non-union. Internal fixation by open reduction undoubtedly allows earlier active motion of neighboring joints.

Whereas "each onto himself must be his final rule," we might consider briefly some of the problems in the treatment of the individual bones to emphasize the principle of choice between the conservative versus the radical treatment of a fracture:

In a fracture-dislocation of the head of the humerus, as in all other fractures, the age and occupation of the patient must be considered. In a young or middle-aged patient who must perform laborious work open operation for the restoration of the head of the bone within the glenoid fossa, if such procedure is possible, or removal of the humeral head can be advocated more readily than if the patient is elderly or employed in a sedentary occupation.

Fracture of the middle of the shaft of the humerus offers one of the great problems in the treatment of fractures because of the incidence of delayed and non-union. It is impractical to suggest any one form of treatment for this type of fracture. I desire to again emphasize that, provided conservative methods fail to hold the fragments in satisfactory immobilization, open reduction with some form of internal fixation should be attempted at an early date.

In fractures of the lower end of the humerus, especially those involving the condyles and more especially the inner condyle, the deformity and the morbidity of these cases can be greatly reduced and the likelihood of ankylosis of the elbow lessened by early fixation of the condyle by means of a nail, screw or pin. Such fixation permits earlier active motion of the elbow. Open reduction with fixation of the internal condyle of the humerus will be less likely to be followed by loss of the carrying angle. There is another important point to emphasize concerning fractures

about the elbow joint; namely, that ischemic paralysis is less likely to occur following open reduction than by prolonged traction with various forms of external splinting.

In speaking of the treatment of these and other fractures included in this paper I am not referring to fractures in childhood. Nature is especially kind with fractures in children. Measures may be employed with childhood fractures, whereas if we applied the same measures in like fractures with adults the end results might be disastrous. It is rarely necessary to employ open reduction in fractures sustained by children.

Fracture-dislocation of the head of the radius usually requires open operation with the removal of the head of the bone. Otherwise the head is likely to become a foreign body and interfere with the future usefulness of the elbow joint. After the removal of the radial head there is a tendency for the development of myositis ossificans. In order to minimize the danger of this complication it is well to encircle the upper end of the remaining fragment of the radius with a strip of fascia or Baer's membrane.

One who treats a large number of fractures must be careful not to expose himself too frequently under the fluoroscope, but I know of no fracture which is more satisfactorily treated with the use of the fluoroscope than fracture of both bones of the forearm. A large majority of these cases can be reduced under general or local anesthesia and held well with moulded plaster-of-Paris splints. If conservatism fails open reduction should be attempted and internal fixation applied. The use of wire or non-absorbable suture material for fractures of the bones of the forearm is unsatisfactory. A Sherman plate or the diamond graft of Gallie is preferable. I have not as yet had sufficient experience with the new Roger Anderson apparatus for the reduction of both bones of the forearm. My only objection to this apparatus is that it entails the application of circular plaster-of-Paris, the use of which I rather dislike.

Colles' fracture can usually be satisfactorily reduced if the fracture is reduced early under a local or general anesthetic. If such reduction cannot be made by conservative

manipulation, open reduction should be instituted.

Compressed fractures of the vertebrae unassociated with pressure upon the cord can be treated conservatively by hyperextension. I do not advocate the Hibbs operation or any modification of the Hibbs for this type of injury. In the case of a compressed fracture associated with cord injury with a crush fracture of the spine fixation by means of bone-graft or the Hibbs operation is preferable to the conservative method of treatment.

Fracture of the neck of the femur involves so many problems as to the age, occupation and general physical condition of the patient that to properly evaluate the various methods of treatment for this particular injury would require a lengthy paper in itself. The end result of this type of fracture depends largely upon the blood supply to the proximal fragment, a problem which the surgeon can only surmise by the age and general condition of the cardiovascular system of the individual patient. The conservative treatment of fractures through the narrow portion of the neck consists largely in the application of the Whitman cast or one of its modifications. The nursing care is simplified and the general condition of the patient improved by the use of this type of cast rather than by the antiquated treatment with sand bags or Buck's extension. When the patient's age and general physical condition will warrant, the operative treatment offers the advantage of better anatomical reduction and firmer immobilization. This operation, which consists of a fixation of the fragments by various means, such as nails, pins, beef-bone, ivory and autogenous pegs, is technically difficult and should only be attempted by those who have gained experience through association with those who are thoroughly familiar with the technique of the operation. Of these various methods, I believe that the Smith-Peterson technique offers the best result with the least amount of additional shock.

The treatment of a fracture of the shaft of the femur at its different levels taxes the ingenuity and the experience of the surgeon. Fractures of the femur demand a larger variety of apparatus and appliance at one's dis-

posal. In dealing with a fracture of the femur the same rule holds true as in a fracture of any other bone of the body; namely, that conservative methods should first be attempted. Conservative measures include manipulative reduction, reduction by the Boehler technique, by the Anderson well-leg splint, by Russell extension, by skeletal traction with the use of calipers, Steinman pins and Kirschner wire. Traction on the soft parts will seldom suffice, excepting with fractures in children or in those cases with a minimum amount of overlapping of the fragments. The proper choice of one of these conservative measures may suffice. If the conservative treatment by one of the above-mentioned methods fails, open reduction must be attempted. The Sherman plate, the removable screw of Carrell, Parham bands or other means of internal fixation may be employed, depending upon the character of the fracture. The Parham band must usually be removed after union is obtained. With the use of plates and screws for internal fixation it is imperative that only those plates and screws approved by the United States Bureau of Standards be utilized.

A few words will suffice in the discussion of the conservative versus the operative treatment of fractures of the patella. Conservative treatment should be employed only in those cases of fracture with slight separation of the fragments and minimum tearing of the extensor tendon and capsule. Open reduction for fracture of the patella is unassociated with shock and renders not only a stronger knee but also decreases the morbidity.

The reduction of fracture of both bones of the leg may be attempted by one of several conservative methods, by traction and manipulation with the use of the Boehler apparatus, by the use of the Roger Anderson apparatus, or by skeletal traction. If, again, reduction is impossible either by manipulation or traction, open reduction with internal fixation, with the use of a Sherman plate, should not be delayed. Early weight-bearing with the use of a proper brace is strongly advocated in the case of fracture of both bones of the leg. Since we have employed early weight-bearing we have had no case of either delayed

or non-union in fracture of both bones of the lower leg.

The problem of Pott's fracture is very similar to that of Colles' fracture. If the Pott's fracture is reduced early under a general anesthetic a good result is usually assured. Many cases of Pott's fracture are not properly reduced. The unreduced lateral or upward dislocation of the astragalus results in a wide, weak, painful ankle. Skeletal traction on the os calcis may be indicated. The only operative procedure which I have found necessary has been tenotomy of the tendon of Achilles. This method is condemned by some surgeons, but I have found it essentially useful.

It is hardly within the province of this paper to discuss the question of the various forms of treatment of compound fracture, the relative merits of the Orr treatment, the instillation of Dakin solution by the Carrell technique and the question of debridement with primary or secondary closure of the wound.

What are the dangers of over-conservative treatment of a fracture; that is, by attempting conservative treatment over too long a period of time?

1st—Too many attempts at closed reduction may be a causative factor of delayed or non-union.

2nd—Too many attempts at closed reduction cause a greater amount of discomfort and shock to the patient.

3rd—The use of prolonged external traction or splinting prevents sufficiently early active motion of the neighboring joints.

What may be considered the dangers of open reduction?

One should not hesitate to operate upon a fracture because of the fear of infection. If technique is properly carried out there should be no more danger of infection in performing an open reduction than in performing a laparotomy. The Lane technique is emphasized, but I do not believe that it is as necessary to carry out the details of the Lane technique as it is to treat the soft tissues gently, not to allow forcible traction, and to check all hemorrhage.

The open reduction with the use of plates has been decried because of the possibility of

breaking or bending of these plates. If proper plates are used—those approved by the Bureau of Standards—this complication is greatly minimized.

To summarize the more important points of the conservative versus the radical treatment of fractures we would emphasize:

1st—Immediate splinting of a suspected fracture—"Splint 'em where they lie."

2nd—The earliest possible fluoroscopic or x-ray study of the fracture.

3rd—An early attempt at reduction and fixation of the fragments under local, general, spinal or nerve block anesthesia.

4th—If after a fair attempt conservative measures fail, open reduction with internal fixation of the fragments.

5th—Do not delay radical procedures for too long a period of time.

319 S. 16th Street.

DISCUSSION

DR. I. L. FLINN (Wilmington): I appreciated very much Dr. Owen's paper. I have heard him before and he always gives the same sort of talk.

There isn't much to discuss so far as the paper is concerned, except that I did appreciate very much his casting a slam at the fracture box. Speaking on that particular subject, I have seen lots of cases here that have had nothing but linear fractures, especially in the lower part of the tibia, linear either oblique or transverse, where they have been put to bed within a fracture box for two or three weeks until the swelling has gone down, and then a circular plaster cast has been applied and the patient been allowed to leave the hospital. In several of those cases the x-ray taken just before the plaster cast had been applied showed a deviation from the anatomical line. The reason I bring it up is that it seems to me to be exceptionally bad economics. With a linear fracture it is perfectly simple to put the plaster cast on immediately and send the patient home in three days' time, thereby costing the patient or the hospital the difference between that and two weeks' time. I have asked several people about this particular thing and why they

waited, and the argument was that you waited until the swelling had gone out because if you put the plaster cast on immediately it would be so loose it wouldn't be any good. That seems to me to be an exceptionally poor argument, for after all, the cast is held by the bony prominences of the foot and knee, and what happens to the plaster cast in between doesn't matter provided you have the fixation points above and below the fracture site. It strikes me as poor economy to use the fracture box. I appreciated the paper very much.

PRESIDENT NILES: Is there any other discussion of this paper?

At this point I would like to ask one question. I noticed that you had one case here with a non-union of the arm. I would just like to know how you get away with those things in Philadelphia? We couldn't do it here. (Laughter) That is a question I would like to have you answer.

Is there any other surgeon who would like to tear this man's paper apart?

DR. JAMES BEEBE (Lewes): I haven't much to say. As Dr. Owen has said, we are situated along the stone road where the automobiles are turned over and we see a number of cases of fractures, compound fractures of the leg, and so forth.

I believe what he said about the conservative treatment. Of course we have the advantage of the advice of one of his colleagues, Dr. Hearn, as well as Dr. Flinn, and they both agree pretty much on the conservative treatment with skeletal fractures and fixation of the spine. I might say that in the last four or five months we have had six fractures of the cervical spine with a lot of cord injury, and with conservative treatment all but one of them is apparently going to make a gradual recovery.

PRESIDENT NILES: There is one other question I would like to ask Dr. Owen. This dislocation of the os calcis, the heel business, backward. Do you find they are most common in men who fall from telephone or electric light poles? I don't know much about it myself, but the reduction of that by the sledge hammer method is interesting to me. I happened to see one of those cases, and this man too had fallen from a broken telephone

pole. When Dr. Flinn walked in with a sledge hammer, you can imagine, being as timid as I am, just what happened. At that time I thought of Dr. Tarumianz and immediately felt it was a case for a psychiatrist. But the operation was successful and I believe he gained at least seventy-five per cent recovery.

Is there any further discussion of this paper?

DR. J. C. PIERSON (Wilmington): It is always stimulating to me to hear Dr. Owen. I have heard him several times. He speaks from such a large experience and with so much enthusiasm and we know we can get some benefit from his comments.

It is natural, I think, that we won't agree on all the particulars that he presents. I think the treatment of fractures allows of some individuality, not only on the part of the fracture itself, it is very necessary to individualize the fracture, but it also allows of some individuality on the part of the surgeon treating the fracture.

I am heartily in accord and would like to add my emphasis to the immediate reduction of fractures, whether it is by the application of skeletal traction which implies a gradual reduction over a muscle pull, or whether it is a fracture around a joint where you immediately reduce it and apply your splint.

Dr. Owen spoke about fractures of the ankle joint. I think we can extend the immediate reduction method sometimes to both bones of the leg. There are some fractures of the tibia and fibula that can be reduced and splints applied immediately, and after a few hours in the hospital they can be returned home and saved a prolonged period in the hospital. I enjoyed the paper very much.

PRESIDENT NILES: Now, Dr. Owen, I will give you a chance to defend yourself.

DR. OWEN: I don't think there has been enough argument and fighting to defend. I am sorry there wasn't more controversy.

As far as the question of suits for damage are concerned, I am in a very fortunate position in that regard in the treatment of these cases. In the first place, with our policemen and firemen, compensation is paid. They receive full pay for all injuries. The hospital

bills are paid. The services are rendered gratis as far as the surgeon is concerned for they go to a ward in the Philadelphia General Hospital, and as yet, none has sued me for malpractice.

Regarding the question of fractures of the os calcis, I believe you answered that question yourself. I think if we get the fractures of the os calcis early and immediately get out the sledge hammer, in a large percentage of the cases we can get an adequate reduction.

I think you will find that in the paper itself, if some time in your leisure moments you want to read it, I brought out a lot of points that time will not permit me to emphasize this morning.

SOME UNCOMMON BONE LESIONS*

B. M. ALLEN, M. D.**

Wilmington, Del.

Mr. President, Members of the Society: I am glad Dr. Niles said that before I got through with my cases instead of afterward for he won't have the opportunity when he sees the mistakes we make. In thinking about writing a paper to give before the Society I thought it would be much better if I would present a few cases demonstrating the difficulties we encounter in diagnosing bone lesions.

In checking over the cases we have had, I have selected a few which presented problems to us, and it seems to me the more we do along x-ray lines the more problems we have.

(Slide) The first case is that of a girl, seventeen years old, white. In 1932 she began having pain around her left knee. That was practically all the symptoms she had—pain around the left knee. She had not to her knowledge had any fever. She noticed the pain getting more frequent and worse at night. Finally she came to the hospital, in January of 1935, which was practically three years after the onset of the symptoms.

The first film to the left is the original film we took. You notice the spindle-shaped deformity of the fibula, in which the cortex is involved, expanded, and the periosteum is

*Read before the Medical Society of Delaware, Wilmington, October 9, 1935.

**Roentgenologist to the Delaware and Homeopathic Hospitals, Wilmington.

thickened, and also, on close observation, you can observe the fact that the periosteum seems to be raised from the cortex.

In a girl seventeen years of age with a spindle-shaped deformity, pain coming on worse at night, one of the first things you want to think of is: an infection or a type of neoplasm? Always in the attempt to find the unusual you sometimes jump to conclusions and make a diagnosis which is not otherwise substantiated. In this case we thought we had all the indications of endothelial myeloma. On that diagnosis, before any biopsy was done, the patient was given 3850 roentgens over a period of about two weeks, I believe.

Here is where a therapeutic test comes in for a roentgenological diagnosis. If that were an endothelial myeloma it should have regressed very rapidly, especially with such a tremendous amount of radiation as she got, which was almost 4,000 R. Instead of that, there was practically no regression at all in the tumor.

So that, when we saw the second film and the third film, then we felt our original diagnosis or suspicion of endothelial myeloma was not correct. Since the child had gotten this radiation and there had been no reduction in the size of the tumor, we thought it best then to do a biopsy.

A biopsy was done and the defect which you see here is the result of the biopsy. Dr. Flinn did the biopsy and it was examined by Dr. Gay, and then was sent to New York and then to Baltimore. One of the pathological reports said it was chronic osteitis; the second said it was simply benign bone dystrophy; the third said it was a sclerosing type of osteomyelitis—which we think this is, the so-called Gare's type of osteomyelitis, or the non-suppurating type.

The men who have had experience with this type of osteomyelitis say these children get along as well without treatment as with it, so that, on these subsequent films here we think there has been some reduction in the size of the spindle-shaped deformity of the fibula, but since those men who have had experience say they disappear just about as well without treatment as they do with it, we can't give radiation much credit for the reduction

in size. At the present time she has no pain and she is going around doing as she pleases.

(Slide) Case 2. I had one case originally and Dr. Hines kindly loaned me another to show the direct opposite of the condition we have here.

In osteogenic sarcoma we have four main types. We have the periosteal, the subperiosteal or medullary, the sclerosing, and the telagentic. This case is of the sclerosing type of osteogenic sarcoma in which there is a marked eburnation of the bone, which in this case is the right ilium. We think it originated in the right ilium, and we think we can see (the hip joint is clear) the characteristics of this, beside the marked ivory-like appearance of the ilium itself, the radiating striations of bone which you see projecting into the soft tumor mass. These cases metastasize very early into the lungs, so always take lung pictures to see if there is any metastasis. This boy shows no metastasis.

As I say, Dr. Hines loaned me this case to show the direct opposites. (Slide) That is the type of osteogenic sarcoma which is highly malignant and usually proves fatal earlier than the first one. Dr. Hines' case was a man who had noticed pain in his shoulder only three weeks before admission to the hospital. He gave no history at all of any injury. A biopsy was done and a diagnosis was made and there was an immediate amputation of the entire shoulder, I think, including a part of the scapula and the outer part of the clavicle. The man died four months afterwards from metastasis to the lung. That is what usually kills these patients with osteogenic sarcoma—metastasis to the vital organs of the body.

By the way, I meant to say something else about this sclerosing osteoblastic type of osteogenic sarcoma. The therapeutic test was applied, and Dr. McElfatriek has given a total of around 5,000 R, and I think there has been no reduction in the size of the tumor.

(Slide) The third case shows how we can all be misled. This child is fifteen years of age. In March 1934, the patient developed pain in the left knee which soon became severe enough to confine her to bed, at which

time she was found to have a low grade fever and was admitted to a hospital outside of this city under a diagnosis of rheumatic fever. She remained in the hospital three months, during which time fever and loss of weight, weakness and progressive anemia continued. X-ray examination of the chest showed pathology in the left lung, the nature of which, the roentgenologist said, was uncertain. On the final examination attention was drawn to the pelvis and they x-rayed the pelvis. By the way, the final examination was postmortem—these are all postmortem films.

We find an extensive bone lesion here, and we present this as a case of endothelial myeloma in which we think the primary lesion was in the left ilium. Then you see this tremendous amount of involvement of all the bones of the pelvis, and you see the involvement of the bones of both shoulders, and an extensive metastatic mass in the left lung and several small ones on the other side.

These endothelial myelomas occur in early life. There is one case reported in the pelvis at eighteen months. More than fifty per cent of the cases occur before the twentieth year. They usually begin with dull pain in one bone, accompanied by intermittent attacks of fever and a progressive anemia. That is one of the distinctions between the two types. That is, osteogenic sarcoma is usually localized, destroying bone and forming new bone in the soft tissues beyond, and does not metastasize to other bones, whereas the endothelial myeloma does. They both metastasize to the lungs.

(Slide) This fourth is an interesting case. I have talked with several pathologists and have looked in the literature, and have talked to people who have had extensive experience and they can't recall any cases in which we have had this combination. This is a man thirty-four years of age. In 1931 he noticed he had a swelling of the glands of the right side of the neck. Almost immediately on top of that he developed a swelling of the glands of the left side of the neck. He was treated by deep therapy for those glands on the left side, in the hospital. It was in 1931 he noticed the swelling which was treated and regressed.

He was admitted to the hospital in April of this year, at which time he had a general

adenopathy of all the glands of the axilla and groin, he had a very much enlarged spleen and an enlarged liver, and was very cachectic in appearance. His red cell count was 2,530,000, showing an advanced anemia, and his white cell count was 7,300, which was about normal. He had marked loss of weight. He was treated over the spleen. We first thought it might be a case of lymphatic leukemia. Then he noticed in the early part of 1934 that he began to have some trouble with the left hip, and at the time he entered the hospital he showed this enlargement, this boggy-like condition of the left hip. So we took some films of his pelvis and here is what we find.

We find an irregular destruction of the bones of the left ilium down to about midway in the left femur. To all intents and purposes, from the x-ray alone the diagnosis of carcinoma could be made, but with this generalized adenopathy it made us a little doubtful about this being a secondary carcinoma.

While in the hospital he developed pain in the lower dorsal region, so we took a film of the dorsal region and found he had a destructive lesion in the twelfth dorsal vertebra. The biopsy shows this to be a case of lymphosarcoma with bone invasion, and the bone invasion is the unusual part of this case. Usually it will invade the vital organs and not the bones. That is the point I talked with several men about and they couldn't remember any case where they had had bone invasion from a general case of lympho-sarcoma.

Of course, this must be differentiated from Hodgkin's disease. That is an important point, I think, because frequently you get these mediastinal masses extending out like this and it is difficult to say whether it is lympho-sarcoma or Hodgkin's disease, but I think one point is to ask the patient whether she has pruritus.

A patient came to me and she had large lymphoid nodules extending on both sides of the neck for which she had been treated and had a somewhat distorted mediastinal mass. I said, "How long have you had this?" She said, "For two years." I frequently ask patients what were the first symptoms they had, and so I asked this patient: "What did you

go to the doctor for the first time?" She said, "I went the first time because I itched all over my body."

That is a very, very important symptom in Hodgkin's disease. We don't know why, but if you get a glandular enlargement here, plus a generalized itching, the chances are that you are dealing with Hodgkin's disease.

(Slide) The fifth is a case that we thought we got very early. The patient is white, aged sixteen. He noticed several nodules on his head in July 1934. He did not consult a doctor until October 1934, and the doctor made a biopsy of one of these nodules, which was examined by Dr. Gay. Dr. Gay made a diagnosis of endothelioma arising from lymphoid tissue or bone. I want to congratulate Dr. Gay on that very accurate observation, as after later events it turned out to be. Those slides were sent to New York and the pathologist made a dissenting diagnosis and called it mycosis fungoides.

He was admitted to the hospital April 17, 1935, stating that he had had pain in his right knee for six weeks previous to his admission. With no particular idea as to there being any connection between the scalp nodules and the knee, the admitting doctor had his right knee x-rayed, and we were rather surprised to find here, immediately above the condyles of the femur, a localized area of destruction beginning in the cortex. Right away we thought, here is a boy sixteen years old with a purely destructive lesion in the anterior cortex of the lower end of the femur, a most favorite site for osteogenic sarcoma. So we thought we were dealing with a very early osteogenic sarcoma of the lower end of the femur.

These patients' films were taken to New York. Dr. Herendun and the two Coleys, the elder and the younger, all saw the films and they all agreed that we were dealing with an early osteogenic sarcoma. The patient was brought back and Coley's fluid together with x-ray treatment was given. There was some controversy between the pathologists about the findings in the scalp nodules and the findings in the femur. Dr. Gay contended that the cell elements found in the femur were the same as those in the scalp. So then we began to work backwards. The probabilities were

that this was an endothelioma originating in the femur and those in the scalp were secondary. The proof of the pudding is always in the eating and here again we have the third test, and that is that this patient was given intensive treatment, with marked improvement and clearing up of the destroyed bone.

The final film over here, which was taken in August of this year, shows a complete healing of the bone pathology in the lower end of the femur. About a week or ten days ago the boy began to have pain in the knee again, and in comparing the latest film with this one we feel that there is beginning involvement again. In other words, a recurrence, so the boy is getting more therapy.

(Slide) The sixth and last case I want to show is a case about which I know nothing and I haven't found anybody else who knows very much about it. For want of a better classification we have classified it under xanthomatosis. Xanthomatoses are supposed to be due to a disturbance in the fat metabolism with a deposition of lipid substances in various parts of the body, especially the bones. There are three recognized types. One is the so-called Pick's disease; the second is the so-called Gaucher's disease; and the third is the so-called Christian-Schiller's syndrome. After going through those three, we felt this boy fitted in more particularly to the category of Christian-Schiller's syndrome. This boy at a very early age in life, according to his mother, had tumefactions around the left elbow. Dr. Flinn examined this boy first and said that the palpable mass felt more like a bunch of worms under the skin and we thought it might be multiple hemangiomata, and we are not sure that we are not dealing with two lesions in this boy. But that doesn't account for the lesions in the chest, on the left side. There are two ribs involved with a cystic-like degeneration of the ribs, with expansion of the cortex, and on the right side the same type of tumor involving two ribs. Then, coming to the femur, you notice a defect in three places.

When Christian published his so-called Christian-Schiller syndrome, he thought he had a triad of symptoms which always spelled his particular form of xanthomatosis; that is, diabetes insipidus, exophthalmus, and

bone lesions of this particular character. They found out on further investigation, however, that the cases Christian reported all had either involvement of the pituitary, which would give diabetes insipidus, or involvement of the orbit which would give your exophthalmus. So, while we have this general syndrome known as Christian-Schiller's syndrome, it doesn't always mean any particular type. In other words, the symptoms that the patient gets in this particular disease are due more to the location of these fatty deposits than anything else, and in Christian's disease it was found more in the pituitary and the orbit.

This child should have his blood chemistry done. He should have an increase in cholesterol if this is Christian-Schiller's syndrome. The family has not been at all cooperative, so we haven't been able to get a biopsy. After we get some of those things done and a biopsy we may have to change that diagnosis.

By the way, another thing in favor of Christian-Schiller's syndrome is that the skull is always involved, and we find the skull is involved here. But after we get a biopsy we may have to change that diagnosis, and it may turn out to be something else. But for the present time we carry this picture as a probable case of Christian-Schiller's syndrome.

909 Washington Street.

DISCUSSION

PRESIDENT NILES: You have heard this most instructive paper. I would like to hear some discussion of it.

DR. G. C. McELPATRICK (Wilmington): Dr. Allen has shown some very interesting cases, especially the first case, the endothelial myeloma. This case brought out that the therapeutic test was to apply therapy treatment. That is very good, but there is still a step before we should do the therapy—I think he will bear me out in this—and that is that suspected cases of endothelial myeloma should never be treated until a Wassermann is taken. I think that is an important point, and I think possibly it would apply to any bone disease, even in the fourth case he presented, with carcinoma of the lower end of the femur, which also had deep therapy. I feel that that case should have a Wasserman. I think that

is an important point. I think in all of bone conditions where we are not sure, before we apply the therapeutic test of deep therapy, we should take a Wassermann. I think it will help us to rule out other possible conditions.

Dr. Allen, of course, has presented here a lovely set of bone conditions and, as he admits himself, if he had not had the cooperation of the men with him he would have had a lot of difficulty in making a diagnosis. I think too much is laid on the x-ray man to make a positive diagnosis inside of three minutes. I think we should cooperate more with the x-ray man; we will get better results and better diagnoses. In a good many of these cases, I think it is almost impossible, even with all your history, to turn around and make a diagnosis without repeated examinations, possibly every month for four or five or six months. Dr. Willard had a case of a child who had had pain in the hip. The x-ray was negative month after month starting in January, and it was only in May that we discovered the youngster had a tubercular lesion.

PRESIDENT NILES: Is there further discussion?

DR. IRA BURNS (Wilmington): The bone cases which Dr. Allen has shown certainly show definitely how difficult and intricate those things are. Even with all the study that has been done it is a most difficult thing even with the leading men.

With regard to the Wassermann, Dr. Flinn indicated that a Wassermann was taken, but not only the Wassermann but every other means of eliminating syphilis should be taken. The Wassermann alone is by no means evidence that you are free from syphilis, and some antisyphilitic treatments sometimes can be very well done.

Dr. Allen mentioned that the knee in the second case, I believe, the sclerosing type apparently, that had been cured after treatment. Of course, he doesn't mean to say "cured" in the ordinary sense at all, he probably meant to say it was arrested, because malignancies, as everybody knows, are practically never-cured. I think we all realize that they have to be gone at more and more vigorously and persistently and consistently than we have ever done, because our records

show that malignancies, carcinoma particularly, have recurred after breast amputation, I think, after a matter of twenty-eight years. I am sure he didn't mean to indicate that the patient seemed to be cured, but at any rate I think in dealing with malignancies certainly the word "cured" is the last word to be used.

PRESIDENT NILES: Is there any other discussion of this paper?

DR. I. L. FLINN (Wilmington): I want to fill out a little bit on one of Dr. Allen's cases that he didn't happen to know about. I saw the case of Christian-Schiller's disease yesterday. Originally when he came in he was complaining of pain in the chest, and it was over one of those lesions in the ribs. As Dr. Allen said, the family was very uncooperative at that time. Since then that whole condition has cleared up. He has no more pain there, and I think probably in the course of a few more months we will be able to get him in and study him.

In regard to the first case which turned out to be Gare's osteomyelitis, we went through the literature in an attempt to find something about it, and outside of Gare's first article, which is incomplete because there was no pathological work done on it, there is practically nothing except the report of cases. So that, in this particular condition it is very difficult to find out just exactly what Gare's osteomyelitis looks like from the histological picture. That is our guess because the condition cleared up completely; after what amounted to a decomposition of the osteomyelitis the wound healed in short order, so that we are literally forced to call it Gare's type rather than any of the other bone conditions.

PRESIDENT NILES: Is there any other discussion of this paper? If not, Dr. Allen, will you close?

DR. ALLEN: I have nothing further to say except that I appreciate the discussion very much by Dr. McElfatrik, Dr. Burns, and Dr. Flinn.

With regard to the Wassermann, it was done in all those cases but I failed to mention it in my hurry to get through.

With regard to Dr. Burns' point, if I said "cured," what I really meant to say was that

the bone at that point was apparently cured from the standpoint of x-ray evidence, and we know, particularly in endothelial myeloma, that it is liable to occur in bones other than the original site. But in the last case that I showed, the boy is having a recurrence in the original site.

WOMAN'S AUXILIARY: A. M. A.

A. M. A. HEADQUARTERS—OLD AND NEW

In 1845 Dr. Nathan Smith Davis, a graduate of 1837 of the College of Physicians and Surgeons of the Western District of New York and a practitioner in Binghamton, presented a resolution to the New York State Medical Society that a National Medical Convention be established. This resolution was adopted and accordingly on May 5th, 1846, 119 delegates from 14 States (Vermont, New Hampshire, Massachusetts, Connecticut, New Jersey, Pennsylvania, Delaware, Maryland, Virginia, Georgia, Mississippi, Illinois, Indiana and Tennessee) met at the University of the City of New York and formulated definite plans for a National Medical Convention. One year later to the very day—May 5th, 1847—the delegates convened in Philadelphia in the Hall of the Academy of Natural Sciences and two days later—May 7th, 1847—resolved themselves into the American Medical Association with Dr. Nathaniel Chapman of Pennsylvania as first president.

Until 1883 headquarters were "under the permanent secretary's hat." The annual four-day session and the publication of its transactions constituted the major part of the Association's activities directed largely by Dr. William B. Atkinson, who had been elected permanent secretary in Baltimore in 1866. Dr. Atkinson served until 1899.

In 1883 the Association decided to publish a Journal very largely at the suggestion of Dr. N. S. Davis, now civic and medical leader in Chicago. From his own private office on July 14th, 1883, appeared the first Journal of the American Medical Association. Dr. Davis was the first editor.

As the work of the Association grew, the headquarters were moved successively to 68 Wabash avenue (Nov. 24, 1888), to 86 Fifth

avenue (Sept. 1, 1894) and to 61 Market street (May 1, 1896).

In 1902 with a circulation of 25,000, with the Market street lease terminating and additional space impossible to secure at this location, the Board of Trustees recommended and were authorized to purchase ground for a permanent home. On March 2nd, 1902, the five brick houses standing on the 100x80 feet at the northeast corner of Dearborn street and Indiana avenue (now Grand avenue) were acquired for \$42,646.96.

By January, 1903, there had been constructed, equipped and occupied a three-story and basement stone-trimmed brick building 80x40 feet facing Dearborn avenue on the north corner of the property at a cost of \$41,322.90.

The adjoining property to the east with 40 foot frontage on Indiana avenue, extending 100 feet to the alley on the north (occupied by two three-story basement houses facing on Grand avenue) was purchased for \$15,000.00 May 26th, 1903.

In 1905 a four-story addition was built directly to the east (behind) the original building. To the latter an additional story was added. Four stories and a high basement now occupied the north 2/5 (40x120 feet) of the Association's property.

By 1909 the circulation of the Journal had been increased to 54,000. The collateral printing and publishing business, the work of the Directory Department, the Councils on Medical Education and Hospitals and Pharmacy and Chemistry with its Chemical Laboratory had completely outgrown the present quarters, as well as one of the two houses (three story basement) to the east. More room was imperative.

Plans were submitted to the House of Delegates in Atlantic City in 1909 by the Board of Trustees for the erection of a six-story building of fireproof construction capable of carrying additional floors as the need might arise. Actual work began March, 1910 and the building was completed without interruption of work in any department.

By 1922 the need for more room again became imperative. The Board of Trustees, with the approval of the House of Delegates,

razed the original three story structure with its added (1905) extra floor and completed the present 100x160 building, six story fireproof construction in 1924. In 1930 to this was added a temporary structure for storage purposes.

In 1935 at the meeting of the Association in Atlantic City, the Board of Trustees discussed the need for more space to house the increasing activities of the headquarter's office. At the September meeting of the Board enlargement of the present building was considered, as well as the purchase of a new location. It was finally decided that an addition of two stories with a roof assembly hall would accommodate the needs of the Association for the next ten to fifteen years. Architects' plans were authorized and presented to the Board by Holabird and Root at its November meeting. These plans were approved and work was started under the immediate supervision of the Executive Committee and the secretary-general manager. Contracts were let and actual work was commenced November, 1935.

The completed structure will cost approximately \$400,000.00 and will be occupied early in the summer of 1936.

AUSTIN A. HAYDEN, M. D.
Secretary, Board of Trustees

The fourteenth annual meeting of the Woman's Auxiliary to the American Medical Association will be held in Kansas City, Missouri, May 11-15. The Auxiliary headquarters will be at the Baltimore Hotel. Mrs. H. L. Mantz, president of the Woman's Auxiliary to the Jackson County Medical Society, is general chairman of convention arrangements. A letter from Mrs. Mantz to the members of the Missouri Auxiliary was published in the March number of the Journal of the Missouri Medical Association. We quote the following passages from her letter:

"If anything further were needed to warm our hearts to the responsibilities attached to the entertainment of the Woman's Auxiliary to the American Medical Association, we found it in the charm and graciousness of our National President, Mrs. Rogers N. Herbert,

(Continued on Page 68)

EDITORIAL

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VOL. VIII

APRIL, 1936

No. 4

THE NEW SURGEON-GENERAL

The successor to Dr. Hugh S. Cumming as Surgeon-General of the United States Public Health Service was sworn into office on April 6, 1936. The individual so sworn was Dr. Thomas Parran, Jr., for the past six years Commissioner of Health of the State of New York, and an M. D. of Georgetown University, 1915. According to the records available to us, Dr. Parran has never engaged in private practice, his entire career, following a two-year internship at Sibley Hospital, Washington, having been spent in public health work. This work has taken him into Alabama, Missouri, Illinois, Kansas and Oklahoma, where he left behind him a record as an able and aggressive sanitarian, a record which attracted to him the attention of the Roosevelt regime when Roosevelt was merely the Governor of the Empire State, and a record there that won a national appointment when the

Governor of that one state was elected the President of all the states.

Time, for April 6, 1936, tells the whole world that the new Surgeon-General "wants socialized medicine, with free drugs and hospital service for every inhabitant of the U. S. who cannot afford them. . . . By the nature of Dr. Parran's plans, thousands of the 167,000 doctors in this country would be obliged to take jobs with city, state or Federal medical agencies. They would thus abandon the legalized privileges of the professional man, the right to deal only with such clients as please them, the right to do whatever they think best for their clients." Without attempting to read between the above lines the obvious implications so well known to the man of medicine, one paramount question emerges: who will win the ultimate victory, the 43-year-old Parran or the 2300-year-old profession?

Men of the Parran type, who have never earned a single dollar in private, competitive practice are the very ones who would be expected to advocate socialized medicine, with its monthly check on the exact date, its smug sense of security from budgetary problems, its placid compliance with political string-pullers, its stultifying self-abnegation and its scientific suicide. If Dr. Parran has any delusions as to his ability to use his new Federal office for the advancement of medical socialism let him ponder deep and long over these simple facts! (1) this country is normally overwhelmingly Republican; (2) the present Democratic administration represents merely an evanescent episode (the like of which we privately hope will never be repeated); (3) socialism has no place in the American scheme of things and probably never will have; (4) the people of this country do their own thinking, without the aid of the congenital bureaucrats; (5) the profession in this country is both intelligent and organized; and finally, (6) both people and profession have already had their fill of a "planned economy," a "life more abundant," and a tax more onerous.

Our private opinion is that Dr. Parran will make, as heretofore, an able sanitarian and

an accurate statistician, but as a medical socialist, as a maker of professional policies, and as a mold of public medical opinion he will prove as ineffective as old King Kanute and his broom against the sea. And we also predict that having reached, at 43, the most publicized salaried medical job in these good old states he will be content there to remain till the retirement age, something like a quarter of a century, even though three-fourths of that time will (according to past experience) be spent under Republican administrations.

Nevertheless, it behooves the entire profession to keep its eyes on Dr. Parran and his Public Health Service, to the end that neither of them has a chance to foist socialized medicine on an unwanting profession or an unwitting public.

For the past five years Dr. Parran has been treasurer of the American Public Health Association, and this year is the president-elect, assuming office next October. Under date of April 2, 1936 we are in receipt of their news release which states that "the oldest and most powerful association of public health workers in the United States, the American Public Health Association, will convene" Modest little outfit, eh?

The credit for the authorship of the little poem entitled "The Doctor," which was published in *THE JOURNAL* last month (page 53) belongs to Mr. Jules H. Rothschild, of Wilmington. We regret that last month's publication merely listed the poem as "contributed."

CALL FOR PAPERS

The program for the next annual session of the Medical Society of Delaware is now being arranged. The secretary, Dr. William H. Speer, announces that any member of the Society who wishes to present a paper must submit his name and address and the title of the paper, to the secretary on or before May 15, 1936.

Dr. M. A. Tarumianz has been honored with the appointment as chairman of the Committee on Outpatient Clinics and Social Service Work of the American Psychiatric Association. Dr. Tarumianz will attend their annual convention at St. Louis May 4-9.

WOMAN'S AUXILIARY: A. M. A.

(Continued from Page 66)

Nashville, Tennessee, who went to Kansas City in November for the first convention conference. We were gratified when she approved wholeheartedly all the accommodations and facilities for making this the best convention so far.

"Yes, we are just that ambitious, for in addition to housing the American Medical Association sessions and its great exhibits in our new \$5,000,000 municipal auditorium, we are hoping that a spirit of friendliness will pervade each and every gathering, business or social. We want this to be remembered as the 'friendly convention' . . . Our entertainment plans are being made to include every woman attending the convention, regardless of Auxiliary affiliation."

Further announcements of the Annual Convention will be given in the May issue of the News Letter.

A bridge party followed by tea was given by the Delaware Auxiliary March 25, for the benefit of the Hygeia Committee. The party was held at the Washington Heights Century Club and was well attended. Mrs. Willard Smith presented a painting, done by her brother, which was given as a door prize. It is planned to place subscriptions to *Hygeia* in various institutions not now receiving this magazine. Mrs. Thomas Baker was chairman of the benefit affair, assisted by Mrs. L. J. Jones, Mrs. J. H. Mullin, Mrs. N. W. Voss, Mrs. M. B. Holzman, Mrs. C. L. Munson, Mrs. C. L. Hudiburg, Mrs. G. B. Beatty, Mrs. R. A. Lynch and Mrs. Roger Murray.

A sewing meeting was held at the home of Mrs. Gerald Beatty on March 17. The next meeting will be at the home of Mrs. Lawrence Jones, 1010 Delaware avenue, on Tuesday evening, April 21.

Members of the Auxiliary have been urged to attend the Health Institute in Philadelphia the second Tuesday in April.

The next meeting of the State Society will be held May 19, probably in Smyrna.

DELAWARE ACADEMY OF MEDICINE

Effective April 1, 1936, the following are the officers and committees for the ensuing year:

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House Committee (appointed)—Bartholomew M. Allen, M. D., chairman; Lawrence J. Jones, M. D., George C. McElpatrick, M. D., J. Draper Brown, D. D. S.

MISCELLANEOUS**Philadelphia's Post Graduate Institute**

Provision has been made for an expected attendance of at least 1,000 at the Philadelphia County Medical Society's Post Graduate Institute, to be held in the Bellevue-Stratford Hotel, Philadelphia, April 20 to 24, inclusive.

Response to the preliminary announcements

has exceeded the committee's fondest hopes, reports its chairman, Dr. Rufus S. Reeves. Letters of inquiry have been received from physicians in 25 states, as far west as Missouri, as far south as Alabama, and as far north and east as the New England states.

In view of the widespread interest in this initial effort by the county society of an outstanding medical center to provide advanced instruction for practicing physicians, it is virtually certain that the Institute will become an annual event.

This year's program, dealing entirely with cardiovascular and renal diseases and their far flung ramifications, is being presented by 53 leading members of the faculties of the University of Pennsylvania School of Medicine and Graduate School of Medicine, Jefferson Medical College, Temple University School of Medicine, and the Woman's Medical College of Pennsylvania.

Registration, open to all physicians who are members of their local county medical societies, will begin at 10 a. m., Monday, April 20. The only charge is \$5.00, to help defray the expenses of the Institute. Following a luncheon in the hotel, the scientific program will get under way at 2 p. m. Morning and afternoon sessions will be held on Tuesday, Wednesday, Thursday and Friday. Since there is no division of the program into sections, only one paper will be read at a time, and all attending will be able to listen to the entire program.

In addition to the program there will be an interesting arrangement of technical exhibits in adjoining rooms, covering a wide range of articles used by the physicians or their patients. Cooperation of the exhibitors to make the Institute a success is heartily appreciated by the committee, Dr. Reeves states.

Committee for the Study of Suicide

An organization to be known as the *Committee for the Study of Suicide, Inc.*, was incorporated last December under the laws of the State of New York and began its activities early in January. The committee may in time increase its present membership of ten to a total number of twenty. The Board of Directors and the officers of the new corporation are: Dr. Gerald R. Jameison, President; Mr.

Marshall Field, Vice-President; Dr. Henry Alsop Riley, Treasurer; Dr. Gregory Zillboorg, Secretary and Director of Research; Miss Elisabeth G. Brockett, Dr. Franklin G. Ebaugh, Dr. Herman Nunberg, Dr. Dudley D. Shoenfeld, Dr. Bettina Warburg.

The committee plans to undertake a comprehensive study of suicide as a social and psychological phenomenon. To achieve this the following general outline was adopted.

1. *Intramural studies* of individuals inclined to suicide in selected hospitals for mental diseases. These will embrace constitutional, neurological, psychiatric and psychoanalytic investigations of the phenomenon with special reference to therapy and prevention. This part of the study will include the investigation of suicidal trends or ideas of death emerging in organic deliria.

2. *Extramural studies* of ambulatory cases afflicted with suicidal trends or with obsessional wishes for their own death. These studies will be primarily therapeutic in nature, the cases to be treated in especially selected out patient clinics and by qualified psychiatrists and psychoanalysts. Regular "control seminars" to follow and to supervise the course of the cases under treatment will be held under the guidance of the committee. The medical and neurological status of all cases will be a prerequisite of each case record.

3. *Social studies* of suicide will be undertaken along the following general lines. Various attempts at suicide will be followed up by experienced psychiatric social workers; all cases will be studied from the standpoint of social background and history and those who failed in their attempts or have recovered from injuries following a partially successful attempt (prolonged unconsciousness or physical illness) will be urged to submit to psychiatric and psychoanalytic treatment in the hands of the intra- or extra mural therapeutic agencies which will be available to the committee.

4. *Ethnological studies*, i. e. comprehensive investigation of suicide among primitive races, will be one of the first concerns of the committee, for suicide is a rather frequent occurrence among many primitive races still extant and when studied may throw some

light on suicide as a psycho-biological phenomenon. It is planned that an expedition headed by a psychiatrically schooled anthropologist, a psychiatrist and a psychoanalyst should work for a time in a region such as the Melanesian Islands or the Gulf of Papua, and in the interior of the Mexican Northwest as well as among some of the North American Indian tribes. Further details of this plan will be elaborated.

5. *Historical studies* of suicide will be pursued systematically under the auspices of the committee, so as to make available a scientific history of the phenomenon as a social and medico-psychological problem.

The committee was organized under the guidance of its first chairman, the late Dr. Mortimer Williams Raynor, Medical Director of Bloomingdale Hospital, who died on October 5th, 1935.

Dr. Henry E. Sigerist, Professor of the History of Medicine at Johns Hopkins University, and Dr. Edward Sapir, Professor of Anthropology at Yale University, are consultant members of the committee. They will advise and guide in that part of the work which touches their respective fields.

The executive offices of the committee are located at Room 1404, the Medical Arts Center, 57 West 57th Street, New York City, and will be in charge of an executive assistant.

Visiting Nurse Association

A recent meeting of the Medical Advisory Board was held in conjunction with the Nurses Committee to discuss the propriety of the Visiting Nurse giving, as ordered by the physician, various medications hypodermically.

In November, 1930, a ruling was made by the Medical Board against serums and vaccines. But recently so many new lines of treatment have been developed, which physicians have requested the Visiting Nurse to give that a new ruling was needed for the organization to meet these demands.

Accordingly, on February 24, 1936, the Medical Advisory Board made this ruling: That the nurse may give the following remedies subcutaneously when ordered by the physician, and as an emergency measure only: atrophine, codeine, nitroglycerine, caffeine so-

dium benzoate, other alkaloids commonly used hypodermically. The nurse shall not give any other drug used for the purpose of treating patients, except insulin may be given when it is impossible or impracticable to train some member of the family to give the treatment, or where it is intended to be given for a short time to stabilize the patient. Exception is also to be made of corpus luteum or other ovarian extracts used in pregnancy.

Transfusion of Cadaver Blood

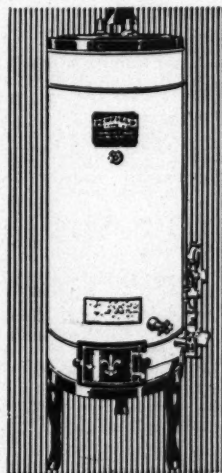
S. S. Yudin, Moscow, U. S. S. R. (*Journal A. M. A.*, March 21, 1936), states that transfusion of cadaver blood was demonstrated in animal experiments and proved its therapeutic value in a considerable clinical material. Cadaver blood obtained from six to eight hours after death remains sterile and preserves its living properties. The recipient of cadaver blood is afforded ample safeguards by serologic tests of the blood, a bacteriologic checkup as to its sterility, and a careful necropsy. Because of fibrinolysis, blood of individuals dying suddenly remains fluid and

can be preserved for more than three weeks. The therapeutic effect of cadaver blood does not differ from that of the blood from living donors. The technic of obtaining blood from a cadaver is simple and does not require any special apparatus. The jugular vein is severed and a glass cannula to which a rubber tube is attached is introduced into each end of the vein. The cadaver is then placed in the Trendelenburg position and the blood is allowed to run into a 500 cc. glass flask. The neck of the bottle is stoppered with cotton and the bottle is placed in a refrigerator. Organization of stations for collection of fresh cadaver blood should offer no difficulties in the larger cities, particularly in the large hospitals for emergency cases. The supply could come from traffic accidents as well as from the medical service where deaths from coronary thrombosis and angina pectoris are not rare. The author's experience with cadaver blood transfusions embraces 924 transfusions. Besides, his clinic sent out more than 100 flasks of cadaver blood to various hospitals and clinics.

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